

24 Emory Int'l L. Rev. 209

Emory International Law Review
2010

Discovering Great Opportunity in the Midst of Great Crisis: Building International Legal Frameworks for a Higher Standard of Living

INTERNATIONAL OBESITY: LEGAL ISSUES

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The World Health Organization (“WHO”) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹ This definition of “health” was adopted by WHO in July 1946 and entered into force officially in April 1948.² Over sixty years later, the international community is now facing a global epidemic that is threatening the health and well-being of individuals across the world. With more than 1 billion overweight adults globally and at least 300 million obese adults, the world is facing an obesity epidemic that poses serious global health consequences.³ Currently, numerous interventions and policies have been implemented across the world to combat this epidemic. This Article examines the current international legal framework around obesity and also discusses the myriad of policy and legal interventions various countries and jurisdictions have implemented. This Article also addresses certain challenges policy makers face when attempting to implement such interventions, including potential unintended consequences and legal issues that may be implicated when instituting legal and policy interventions to curb this epidemic. In moving forward to ensure all individuals can achieve WHO’s definition of health, and in the spirit of current international law and recently-developed global strategies to counteract obesity, this epidemic must be addressed. However, when implementing strategies to counteract this enormous public health challenge, unintended consequences and legal issues should be considered.

***210** The international community is facing many challenges. For instance, according to the Wall Street Journal, for the first time since 1945, the world economy shrank in the last quarter of 2008.⁴ The financial crisis has not only affected the United States--Italy, the United Kingdom, Germany, and Japan are also in a recession.⁵ Alistair Darling, the U.K. Chancellor of the Exchequer, in an opinion piece appearing in the Wall Street Journal, noted that “international cooperation is essential in everything we do to support the economy” and that “[w]e are all affected by what happens to our neighbors.”⁶ He also commented that “[w]e must seize the moment and act together, urgently and with determination . . . [b]oth to deal with the problems that confront us today, and as we build toward recovery tomorrow.”⁷ Thus, recognizing our global interdependence, financial experts have called for an unprecedented global response to the current economic crisis. Likewise, global cooperation is essential to combat other problems facing the international community, e.g., the staggering health problems and associated costs caused by non-communicable diseases associated with obesity. The combined direct and indirect cost of obesity in the United States alone was estimated to be \$123 billion in 2001.⁸ Furthermore, the economic downturn may also increase obesity rates as economic hardship could force consumers to replace more expensive nutritious food with less expensive, higher calorie products.⁹ Thus, it is apparent that international efforts to support change are essential to tackle global problems.

I. Statistics

According to WHO’s Global Strategy on Diet, Physical Activity and Health (“Global Strategy”), “[a] profound shift in the balance of the major causes of death and disease has already occurred in developed countries and is under way in many developing countries.”¹⁰ Mortality and disability ***211** attributable to non-communicable diseases are also rapidly expanding in the developing countries.¹¹ In fact, according to the Food and Agriculture Organization of the United Nations (“FAO”), for the first time, the number of individuals considered to be overweight around the world rivals those who are underweight.¹² Developing nations are not immune from this epidemic as they are also facing a potential obesity problem.¹³ According to WHO, even in the poorest parts of the world, major risk factors for chronic diseases are increasing.¹⁴

Overweight and obesity are also adversely affecting children around the world. According to Youfa Wang and Tim Lobstein, in many parts of the world for which data are available, the prevalence of childhood overweight has increased.¹⁵ There is growing evidence that overweight and obesity among school-age children, which also may include pre-school children, are

becoming an increasing public health epidemic.¹⁶ This is especially concerning as children who are overweight are more likely to become overweight adults.¹⁷ Children in developing countries have a prevalence of overweight from 10-25%, and the obesity prevalence ranges from 2-10%.¹⁸ WHO considers childhood obesity an epidemic in some areas of the world and, at the least, on a dangerous rise in others.¹⁹ WHO further estimates that globally, 22 million children under the age of five are overweight.²⁰

Overweight and obesity pose a major risk for many chronic diseases, including type 2 diabetes, stroke, certain forms of cancer, cardiovascular disease, and hypertension.²¹ According to The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, the incidence of heart disease-- which includes congestive heart failure, abnormal heart rhythm, *212 and heart attack--is increased in individuals who are overweight or obese.²² Furthermore, weight gain of eleven to eighteen pounds can increase individuals' risk of developing type 2 diabetes to twice that of individuals who have not gained weight.²³ Obesity is also associated with other conditions such as sleep apnea, a higher prevalence of asthma, and certain reproductive complications.²⁴

Not only are the costs of obesity related to dramatic increases in chronic diseases, but there are global financial costs as well. For instance, in the developed world, it is estimated that 2-7% of total health care costs are attributable to obesity.²⁵ The United States suffers substantially as well: The combined direct and indirect cost of obesity in the United States was estimated to be \$123 billion in 2001.²⁶ In the Pacific Islands in 2004, the economic consequences arising mainly from obesity and diabetes amounted to \$1.95 million.²⁷ WHO's Global Strategy points out that non-communicable diseases--including cardiovascular disease, type 2 diabetes, and certain types of cancer--impose a major economic burden on "already strained health systems, and inflict great costs on society."²⁸ The Sydney Resolution, a call to action delivered in 2008 in Sydney, presents that "[t]here are immense costs to society in lost productivity and increased use of health services. The [obesity] epidemic threatens economic stability in developed and developing countries alike. Families striving to escape the poverty trap are pushed back into disadvantage and despair."²⁹ Also, FAO gravely notes that "[f]or nations whose economic and social resources are already stretched to the limit, the result [of obesity] could be disastrous."³⁰

It is therefore apparent that the costs of obesity are staggering and pose a global threat not only to the world's standard of health but global financial health as well. However, it should not go unnoted that while overweight and *213 obesity are rising in many parts of the world, some countries are still facing hunger.³¹ FAO points out that "[i]t is a bitter irony that as developing countries continue their efforts to reduce hunger, some are also facing the opposing problem of obesity."³² Also, to make the challenge even more complex, some lower- and middle-income countries are currently experiencing the challenges of both malnutrition and obesity simultaneously.³³ Thus, it is apparent that the obesity epidemic is extremely complex. Many facets involve not only an increase in risk of chronic disease but also provide an additional health concern to countries that are facing an obesity and hunger problem simultaneously.

II. Roots of the Obesity Epidemic

From the data available and discussed above, the incidence of obesity and overweight among both adults and children is a major public health challenge. This epidemic has numerous roots that many argue include major changes related to economic growth, urbanization, and globalization of food markets.³⁴ Many point out that these economic and social shifts have led to great innovations and industrial developments.³⁵ It is argued that countries more open to the global economy may grow faster and achieve higher incomes than those that are more closed.³⁶ While increased importation of food has many advantages--including seasonal variation in the availability of food, a range of new products available in all parts of the world, and lower prices-- FAO argues that the industrialized world's increased importation of food is also one cause of the obesity epidemic.³⁷ FAO further notes that "obesity in the developing world can be seen as a result of a series of changes in diet, physical activity, health and nutrition."³⁸ Unfortunately, it appears that, as countries become wealthier and grow economically, they are beginning to acquire obesity as a major public health problem.³⁹ For instance, the consumption of high-fat foods increased dramatically in China when per capita income grew after economic *214 reforms in the 1970s.⁴⁰ Sugar and fat account for more than half the caloric intake in North America and Europe.⁴¹

FAO also posits that the industrialized world's increased importation of foods may be one of the roots of this growing epidemic.⁴² Arguably, this importation of foods that may be higher in sugar and fat has replaced traditional diets that contained a larger proportion of grains and vegetables.⁴³ It also seems that sugar, sweets, fats, and oils all generally become less expensive than other healthier goods.⁴⁴ For instance, "[i]n 1962, a diet containing 20 percent of total energy from fat correlated with a per capita GNP [gross national product] of US \$1475. By 1990, a GNP of just \$750 correlated with the same diet."⁴⁵

The International Association for the Study of Obesity ("IASO") represents the scientific and medical research professions concerned with worldwide obesity.⁴⁶ The International Obesity TaskForce ("IOT"), a research and policy arm of the IASO, asserts that another root of the obesity problem arises from the fact that a much larger proportion of food is now consumed outside the home, which, according to the IOT, has also increased the use of marketing initiatives leading to "larger portion sizes [and] intense competition to ensure products are conveniently located in . . . fast food outlets or in vending machines in

schools, workplaces and city centres.”⁴⁷ According to a Bulletin of the World Health Organization, in the United States alone there are 3 million soft drink vending machines and over 170,000 fast food restaurants.⁴⁸

Decreasing levels of physical activity have also been observed globally.⁴⁹ However, some questions exist concerning whether increased food consumption is a more important factor in the rise in obesity than decreased *215 amounts of physical activity.⁵⁰ It is argued that changes in “energy expenditure” have actually been quite small whereas evaluations of country-level estimates show that an increase in caloric availability is consistent with trends in obesity.⁵¹ Physical activity still remains an important component underlying global health, however, and is addressed in WHO’s Global Strategy as one of the main risk factors for non-communicable diseases.⁵² WHO notes that internationally there have been major shifts toward less physically demanding labor as well as an increased use of “automated transport, technology in the home, and more passive leisure pursuits.”⁵³ There are also other numerous health benefits to increased physical activity that contribute to individuals’ overall health.⁵⁴

Another important component to the roots of the obesity epidemic is that many areas around the world have very limited access to affordable nutritious foods. The term “food deserts” describes such neighborhoods, and in the United States these food deserts seem to be located in low-income rural and urban neighborhoods.⁵⁵ The United States Department of Agriculture (“USDA”) estimates that “about 30 percent of low-income individuals located in low-income urban clusters have low access to supermarkets.”⁵⁶ The USDA further asserts that, based on numerous studies examining the association between restaurant and store access and obesity, it seems that better access to a supermarket correlates with a reduction in the risk of obesity.⁵⁷ The studies also suggest that, on the other hand, better access to convenience stores correlates with an increased risk of obesity.⁵⁸

The roots of the obesity epidemic are complex and multifaceted. Furthermore, some causes of the current global obesity problem still remain controversial. As described below, there are international legal frameworks in place and developing to address this public health challenge.

***216 III. Current International Legal Frameworks**

WHO defines international law as “the body of rules that are binding on states and other subjects of international law, in particular international organizations, in their relations with each other.”⁵⁹ There are international treaties in place that deal, in part, with the issue of food.⁶⁰ For instance, Article 11 of the United Nations International Covenant on Economic, Social and Cultural Rights, entered into force January 3, 1976, recognizes “the right of everyone to an adequate standard of living for himself and his family, including adequate food”⁶¹ Article 11 further declares that it is a “fundamental right of everyone to be free from hunger,” and there should be improved “methods of production, conservation, and distribution of food . . . by disseminating knowledge of the principles of nutrition”⁶² The United Nations Committee on Economic, Social and Cultural Rights, the Committee charged with monitoring adherence to the treaty, further elaborates on these concepts and discusses individuals’ right to adequate food by stating that “[d]ietary needs implies that the diet as a whole contains a mix of nutrients for physical and mental growth, development and maintenance, and physical activity that are in compliance with human physiological needs at all stages throughout the life cycle”⁶³ Furthermore, the Convention on the Rights of the Child, entered into force September 2, 1990, addresses issues including health care and emphasizes that children have the right to develop to their fullest potential.⁶⁴ Article 24 of this Convention states that parties must “ensure that all segments of society, in particular parents and children, are informed . . . and are supported in the use of basic knowledge of child health *217 and nutrition”⁶⁵ These international legal instruments recognize that “the right to adequate food is indivisibly linked to the inherent dignity of the human person and is indispensable for the fulfillment of other human rights”⁶⁶ The main focus of these documents, however, relates to taking steps to ensure that individuals throughout the world are free from malnutrition and hunger, and they do not focus specifically on the challenges related to overweight and obesity.⁶⁷ Both documents entered into force prior to the real threat that obesity now poses to global health.⁶⁸ Both international legal instruments, however, recognize inherently that children and their parents are entitled to realize their full growth and potential, to be free from disease, and to have access to a diet that enables physical and mental growth.⁶⁹ Therefore, these documents provide the basis for the fundamental rights of individuals to reach their potential and to have the right to “adequate food.”⁷⁰

While the above legal instruments do not address obesity directly, they provide a beginning point from which other international legal frameworks can create more specific standards to address obesity. Such frameworks seem to be calls to action and outlines of agreed upon strategies to reduce obesity. For instance, in May 2004, the 57th World Health Assembly (“WHA”) endorsed WHO’s Global Strategy.⁷¹ The Global Strategy seeks to “bring[] about changes in the dietary habits and patterns of physical activity [that] will require the combined efforts of many stakeholders, public and private, over several decades.”⁷² The Global Strategy, however, does not ignore that steps are still needed to curb hunger and malnutrition in some parts of the world, and the document is intended to complement work being carried out by WHO and others that includes micronutrient deficiencies and undernutrition.⁷³ In fact, as will be described further below, in some parts of the world, hunger and obesity *218 are occurring simultaneously, thus demonstrating that both conditions coexist as global health challenges.⁷⁴

Recognizing the public health burden of chronic diseases related to obesity throughout the world, the Global Strategy has four main objectives: (1) reducing the risk factors for obesity related diseases that occur from unhealthy diets and physical inactivity; (2) creating awareness of the positive health effects of preventive interventions; (3) encouraging the "implementation of global, regional, national and community policies and action plans to improve diets and physical activity . . . that are comprehensive[] and actively engage all sectors . . ."; and (4) monitoring data and supporting necessary research.⁷⁵

More specifically, the Global Strategy proposes that governments should provide balanced information for consumers that enable individuals to more easily make healthy food choices.⁷⁶ The document further provides that food and agricultural policies should facilitate and promote public health, e.g. food product promotion should be consistent with a healthy diet and policies should "influence prices through taxation, subsidies or direct pricing in ways that encourage healthy eating and lifelong physical activity."⁷⁷

Furthermore, governmental sectors, various international organizations, experts, and the private sector were all involved in the process of developing another important document--the European Charter on Counteracting Obesity ("Charter").⁷⁸ The Charter was drafted in order to combat the epidemic of obesity and to curb its detrimental effects on "health, economies and development . . .".⁷⁹ This document originated from a November 2006 conference organized by the WHO Regional Office for Europe on counteracting obesity.⁸⁰ The Charter seeks to achieve specific results, such as a decrease in obesity within five years, with a special emphasis on children.⁸¹ The Charter also seeks to reverse obesity trends before 2015.⁸² Furthermore, *219 the document calls not only for changes in individual lifestyles but also for changes in economic, social, physical, and political environments and seeks coordination and cooperation between "governments, nongovernmental organisations, private enterprise, professional networks and the media."⁸³ Nongovernmental organizations--such as the European Public Health Alliance, the International Association for the Study of Obesity, the International Obesity TaskForce, and the International Sport and Culture Association--supported the Charter but also noted that to more effectively diminish this epidemic, government departments and the international community must: (1) coordinate to implement evidence-based actions that include fiscal or other financial measures to improve accessibility to healthy foods, (2) increase the number and intensity of physical education in school and increase opportunities for walking in urban areas, and (3) support the development of more understandable food labels.⁸⁴

Other calls to action have also taken place. For instance, the Sydney Resolution was developed as a "call to action" at the 2008 Oxford Health Alliance Summit in Sydney.⁸⁵ The Sydney Resolution calls on "United Nations' agencies, governments, corporations and businesses . . . professionals, consumers, non-government organisations . . . and individuals to collaborate in taking urgent action to halt the devastating global impact of chronic diseases."⁸⁶ The Sydney Resolution lists five main areas for the "call to action": (1) healthy places, (2) healthy food, (3) healthy business, (4) healthy public policy, and (5) healthy societies.⁸⁷ The document specifies that designing places where it is easy to walk, making healthy food affordable and available, and addressing socio-economic disadvantages will all promote necessary changes to the current obesity epidemic.⁸⁸

IV. Policy Interventions to Combat Obesity

While international documents have been drafted in order to address obesity, there are also numerous policy interventions taking place in many *220 jurisdictions throughout the world. The WHO issued a summary report providing a synopsis related to diet and physical activity interventions aimed at reducing the risk of chronic diseases associated with obesity. According to the summary report, strong evidence suggests that school-based interventions show improvements in knowledge and attitudes, and that schools "should include a diet and physical activity component in the curriculum taught by trained teachers[;] . . . include a food service with healthy choices; and offer a physical activity programme."⁸⁹ The summary statement also asserts that the workplace is an excellent place to offer employees structured ways to increase health.⁹⁰ The WHO states that evidence also points out that including employees in program planning and implementation brings positive outcomes.⁹¹

Countries are beginning to adopt approaches to curb the obesity epidemic. For instance, the United Kingdom's Food Standards Agency has developed a scheme for nutrition labeling using traffic light symbols.⁹² The use of traffic light colors is a simple means to help individuals better understand how their food choices rank from a health standpoint. The scheme provides separate information concerning fat, sugar, and salt and uses red, amber, or green color-coding to indicate whether the levels of the above nutrients are high, medium, or low.⁹³ These codes are voluntary, although the Food Standards Agency recommends that the traffic light colors be used specifically on processed convenience foods such as ready meals, pizzas, burgers, sandwiches, and breakfast cereals.⁹⁴

Regions in Sweden introduced a label in the 1980s as part of an intervention to reduce coronary heart disease in northern Sweden.⁹⁵ All of Sweden now promotes the use of a voluntary keyhole label to help consumers *221 make healthier food choices.⁹⁶ When the symbol appears on packages, it guarantees that the product has a small amount of "total fat, saturated fatty acids, trans fatty acids, added sugars [and] salt as sodium."⁹⁷

Other countries are taking part in smaller scale interventions to address the obesity epidemic as well. For instance, the provision of free vegetables or salads with a meal at a university canteen has been studied in Finland, and other countries are examining the marketing and advertising of certain products.⁹⁸ A recent article noted that Italy's cabinet minister announced that traditionally long lunch breaks involving pasta or meat are "bad for waistlines and the economy, and should be skipped."⁹⁹ These actions are illustrative of the many policy interventions being implemented throughout the world.

V. Legal Interventions to Combat Obesity

In addition to the many policy interventions that have been implemented, legal means are also being used to address obesity. As part of the WHO's implementation of the Global Strategy discussed earlier, the WHO organized a meeting on marketing food and non-alcoholic beverages to children in May 2006.¹⁰⁰ The document produced from this meeting addresses issues concerning exposure and promotion of "energy-dense, micronutrient-poor foods and beverages" to children and notes that "food advertising affects food choices and influences dietary habits."¹⁰¹ Interestingly, the document addresses children's rights and cites to the Convention on the Rights of the Child as well as the right to adequate food set forth in the International Covenant on Economic, Social and Cultural Rights as two bases to address what the WHO refers to as the "adverse impact of marketing on children's health."¹⁰² Findings discussed by the WHO indicate that food dominates advertising to children and this advertising seems to relate mostly to "soft drinks, pre-sugared cereals, confectionary, snacks and fast food restaurants."¹⁰³ Certain countries have used law as a means to address these concerns by regulating the marketing of food and beverages to children. For instance, several laws in Norway regulate such *222 marketing by disallowing marketing activities that conflict with good marketing practice or are otherwise unfair to consumers.¹⁰⁴ Quebec also has a law that deals with advertising to children.¹⁰⁵ In 1978, Quebec enacted the Consumer Protection Act that prohibits all forms of commercial advertising directed at children less than thirteen-years-old.¹⁰⁶ Lastly, in February 2007, the British Office of Communications announced new regulations regarding food advertising to children in the United Kingdom that involved restrictions on the advertisement of certain types of foods adjacent to children's programming or principally directed to audiences below the age of sixteen.¹⁰⁷ However, some have questioned the efficacy of such laws and point out that jurisdictions like Quebec that have instituted such restrictions have not shown significant reductions in child obesity.¹⁰⁸ Other critics, in Britain for instance, argue that the U.K. ban on advertising certain foods to children could result in curtailing educational television for children as cereals, candies, fast food, and snacks account for more than half the food advertisements that fund the production of such shows.¹⁰⁹

Other jurisdictions have determined that a large amount of food is consumed outside the home and have implemented regulations requiring certain food service providers to post calorie information on menu boards and menus. For instance, New York City Health Code Section 81.50 requires certain food service establishments to provide calorie information prominently on menus, menu boards, and item tags ("food items displayed for sale with food item tags").¹¹⁰ Covered food establishments include restaurants belonging to a group of fifteen or more food service establishments that are under common ownership.¹¹¹ New York City established the regulation because they found that New Yorkers were consuming at least a third of their calories away from home but lacked readily available information.¹¹² Without such *223 information, New York City argued that it was very easy for individuals to consume too many calories.¹¹³ Interestingly, the United States Court of Appeals for the Second Circuit upheld New York City's menu regulation in a suit filed by the New York State Restaurant Association ("NYSRA").¹¹⁴ The State of California has also enacted a similar law requiring chain restaurants with at least nineteen other food facilities to provide certain nutrition information regarding their foods.¹¹⁵ For instance, beginning in January 2011, certain facilities in California must disclose calorie content information for a standard menu item next to the item on the menu.¹¹⁶

Another legal means of reducing the obesity epidemic includes banning trans fats. Evidence suggests that the consumption of trans fat raises "bad" cholesterol while lowering "good" cholesterol, which causes the arteries to become clogged and increases the risk of heart attack and stroke.¹¹⁷ For example, as of July 2008, New York City began to phase out trans fat in all city restaurants. The Board of Health in New York City requires that food items must contain less than 0.5 grams of trans fat per serving.¹¹⁸

As the obesity epidemic also faces children some schools are attempting to intervene to curb this health problem. Many schools in the United States are conducting body mass index ("BMI") screening as a way to assess the weight status of students and to identify students who may be at risk for weight-related health problems.¹¹⁹ For instance, Arkansas implemented a statewide BMI surveillance program in 2003, and California students participate in BMI screening as part of physical fitness testing.¹²⁰

There are a myriad of both policy and legal interventions taking place around the world to prevent and reduce obesity in both adults and children. These interventions are varied and range from large-scale policies banning trans fat and requiring calorie posting to small-scale, but notable, *224 interventions.¹²¹ As will be discussed below, both policy and legal interventions raise some concerns and potential unintended consequences that should be examined more closely.

VI. Challenges to Implementing Policy and Legal Interventions

As noted previously, there are many policy and legal interventions taking place around the world to combat this obesity epidemic. Such potential interventions include changes in demand for food; for instance, one legal intervention that has been proposed is raising prices on certain “unhealthy” foods.¹²² However, Shiriki K. Kumanyika, in her article *Global Calorie Counting: A Fitting Exercise for Obese Societies*, points out that “major changes in the food supply . . . raise[] legitimate concerns about the potential for alienating, demonizing, or distorting the industries and people who provide food to feed the world’s populations, and the related potential for compromising nutritional adequacy or dietary quality for vulnerable populations.”¹²³ Kumanyika raises the question of whether policy interventions to raise prices would “in fact, increase the occurrence of hunger and food insecurity?”¹²⁴ Her article further points to the evidence described above that in some developing countries, obesity may occur simultaneously with under-nutrition and poverty.¹²⁵ Kumanyika argues that this raises the concern regarding the “potential adverse effects of food supply changes geared to discouraging overconsumption of calories on the hunger problem.”¹²⁶

Issues associated with eating, food, and obesity are difficult as they exist on a continuum that includes hunger and obesity, but other food related problems as well. For instance, the Academy for Eating Disorders (“AED”), a global professional organization that provides leadership in education and research related to eating disorders, addresses issues related to food and eating.¹²⁷ The AED notes that “[w]hile . . . [obesity] initiatives may be carried out with the *225 best intentions, there is growing concern that they may in some cases contribute to negative self-esteem, body dissatisfaction and eating disordered behaviors among young people.”¹²⁸ The AED points out evidence that suggests an emphasis on appearance and weight control may lead to a promotion of eating-disordered behaviors.¹²⁹ Some authors have also suggested that unlike other major public health problems such as tobacco, “where the goal is to get people to stop a behavior entirely, healthy eating and physical activity exist on a behavioral continuum that may be unhealthy at either extreme.”¹³⁰ Therefore, while school-based interventions have been shown effective in helping to curb the obesity problem, caution should be taken when implementing such interventions. The AED recommends interventions that focus on health and “constructing a social environment where all children are supported in feeling good about their bodies”¹³¹

There are other challenges that may impair the implementation of certain interventions. For instance, as discussed above, the WHO addressed the issue of food marketing to children and indicated that advertising to children seems to focus on “unhealthy foods” such as soft drinks and pre-sugared cereals.¹³² Therefore, as addressed above, certain countries are attempting to regulate such marketing and already have laws in place related to this issue.¹³³ Evidence suggests that advertisements “shape product preferences and eating habits” and that “children younger than eight years of age are generally unable to understand the persuasive intent of advertising and to view it critically.”¹³⁴ While some argue that, given the evidence regarding advertising effects on youth, only healthful foods should be marketed, particularly to children, or a ban on all food advertising to children should be instituted; others argue that jurisdictions that have put such measures in place, like Sweden, Norway, and Quebec, have not shown significant reductions in child obesity.¹³⁵ *226 Furthermore, advertisement watching has become less prevalent with recent technology allowing audiences to fast-forward through most commercials.¹³⁶ Also, some posit that children’s television viewing is not limited to children’s shows, e.g., that children often view programming intended for adults as well, therefore, advertising restrictions geared towards children may not be successful.¹³⁷ To further complicate the debate over food products advertisements, in the United States, there are major constitutional legal issues implicated in banning or even regulating such advertising.¹³⁸ For example, the Supreme Court of the United States has recognized the value of commercial information and determined that “[a]dvertising, however tasteless and excessive it sometimes may seem” is essential in a democracy.¹³⁹ Furthermore, in *Lorillard Tobacco Co. v. Reilly*, the Supreme Court struck down broad tobacco advertising restrictions designed to protect children in Massachusetts.¹⁴⁰ Although the Court noted that the state’s interest in preventing underage tobacco use was compelling, the Court stated that “[w]e must consider that . . . retailers . . . have an interest in conveying truthful information about their [tobacco] products”¹⁴¹ The Court also noted that the use of tobacco products by adults is “a legal activity.”¹⁴² Thus, imposing similar advertising restrictions, at least in the United States, to protect children from certain food advertising may present major legal challenges.

Lastly, there may be other relevant issues involved with instituting changes in food production, pricing, and the enactment of the myriad of laws and policies, such as menu labeling and traffic light symbols, that are worth noting. For instance, as it relates to legal interventions to counter the obesity problem, some argue that such laws “constitute paternalistic intervention into lifestyle choices and enfeeble the notion of personal responsibility.”¹⁴³ Some may even suggest that certain interventions, both policy and legal, may “take the fun out of preparing, sharing, and eating food, with consequent impairment of quality of life.”¹⁴⁴ Sensitivity should also be taken with regard to foods and eating *227 styles that vary greatly throughout the world. A policy or legal intervention that may be successful in one part of the world may even be considered offensive or completely ineffective in another part of the world.

Conclusion

As illustrated above, the obesity epidemic is real and continues to threaten the state of global health. It seems, from the

startling statistics discussed here and in many other articles, that obesity is a staggering public health problem affecting both adults and children that needs to be addressed globally. This growing challenge impedes individuals' abilities to achieve the WHO's definition of health: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."¹⁴⁵ Moreover, the relationship between obesity and chronic diseases--which cuts short and dramatically decreases the quality of life around the world--further complicates these efforts.¹⁴⁶

There are many interventions currently in place and even more being studied and contemplated throughout the world. There is a myriad of international legal documents as well as global strategies and charters, such as the WHO's Global Strategy, that outline the international goals that will hopefully alleviate this challenge in the coming years.¹⁴⁷ Such documents and proposed interventions are rooted in international treaties, such as the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child, that recognize the right of everyone to "adequate food" and the right of children, in particular, to develop to their "fullest potential."¹⁴⁸ However, caution should be exercised so that interventions designed to increase health, while grounded in international law, do not contravene such law. Thus, given the evidence that an obesity epidemic is threatening the global standard of living, healthy eating habits and healthy food, as pointed out earlier, exist on a continuum. Arguably, if such a continuum is not balanced correctly, inadvertent shifts could take place and ²²⁸create unintended effects on hunger or distorted body images and increased eating disordered behavior in youth. Lastly, while public health interventions are necessary to curb this public health epidemic, given that the science and the root causes of obesity are still evolving and consensus may not exist concerning which interventions are effective, changes in both policies and laws should be made with caution and in accordance with applicable laws and regulations, including the U.S. Constitution, as well as with respect towards cultural differences existing around the world.

The world is facing economic difficulties arguably not seen since the mid-1900s and at the same time is burdened with a substantial rise in chronic diseases adversely affecting both developed and developing nations. President Barack Obama has stated that "[w]e are living through a time of global economic challenges that cannot be met by half measures or the isolated efforts of any nation" and that "the American economy is inextricably linked to the global economy."¹⁴⁹ Global cooperation is necessary to tackle the challenges facing the world today and, as noted earlier, in the developed world up to 7% of total health care costs are attributable to obesity. The WHO has pointed out that conditions associated with obesity such as cardiovascular disease, type 2 diabetes, and certain types of cancer are financially burdening already strained health systems.¹⁵⁰ Furthermore, obesity rates in times of economic hardship could increase as consumers feel forced to purchase less expensive, higher calorie products.¹⁵¹ Thus, as the international financial crisis has shown, global cooperation is necessary to counter the health and fiscal challenges facing the world today.

Footnotes

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Acknowledgments: Angela Oliver, Emory University School of Law (2010); Dan Hougendobler, Emory University School of Law (2011); and John Bailey, Georgia State University College of Law (2010) (students who assisted with research).

- ^{d1} Any views expressed in this Article reflect those of the author and should not be attributed to the Centers for Disease Control and Prevention and/or the Department of Health and Human Services. As material in this Article is work prepared by an employee of the Federal Government it is not subject to copyright.

¹ Constitution of the World Health Organization pmbl., July 22, 1946, 62 Stat. 2679, 14 U.N.T.S. 185.

² Id. art. 82; World Health Org., History of WHO, <http://www.who.int/about/history/en/index.html> (last visited Feb. 14, 2010).

³ World Health Org., Obesity and Overweight (2003), <http://www.who.int/dietphysicalactivity/media/en/gsf Obesity.pdf>. WHO defines obesity and overweight by using body mass index ("BMI"), defined as the weight in kilograms divided by the square of the height in meters. Id. According to WHO, a BMI over 25kg/m² is defined as overweight, and a BMI of over 30kg/m² is considered obese. Id.

⁴ Alistair Darling, Op-Ed., International Cooperation Is the Way out of the Financial Crisis, Wall St. J., Mar. 13, 2009, at A11.

- 5 Id.
- 6 Id.
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